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Group purchasing of contraceptives : a feasibility study.

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GROUP PURCHASING OF CONTRACEPTIVES: A FEASIBILITY STUDY

By

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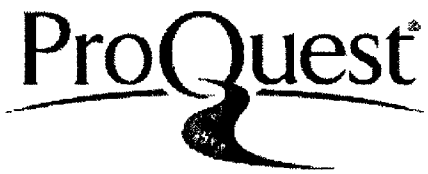

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CHAPTER I

THE NECESSITY OF FINANCIAL RETRENCHMENT IN A PERIOD OF RISING HEALTH CARE COSTS

Introduction

Rising health care costs and expenditures is one of the most serious problems facing our country today. Expenditures for health care have risen from $12.7 billion in 1950 to $322.4 billion in 1982.[1] Rising costs, coupled with a decline in governmental resources, have created new problems in the area of federally funded health care programs.

The decade of the 1980s marks the beginning of a new era for publicly funded health and welfare programs. Social welfare programs inaugurated during the Johnson administration's "Great Society" of the mid-1960s are moving from a funding environment of seemingly unlimited resources to one of increasing competition for limited resources. As programs come under the scrutiny of Congress or state legislatures for continued appropriations, each is asked to justify the continued existence of the program through measurements of success, such as levels of service, population served, and program costs. Programs are being asked to become increasingly more accountable and cost effective.

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[1]James Fralick, "Rx for Treatment of Hyper Health-Care Costs," Across the Board, April 1982, p. 68.

The process of allocating resources among competing demands from various programs becomes more difficult in a period of retrenchment. The question is not who should get how much of an increase, but who should be forced to absorb what portion of the cuts. Family Planning, a federally funded health care program, is a prime example of an organization which has been affected by rising health care costs and decreased federal dollars. In this "era of retrenchment," family planning programs, if they are to survive, must look for creative, innovative ways of allocating scarce resources. As Robert Biller has stated, "Retrenchment makes possible the redeployment of resources in potentially more unique and particularistic ways."[2] According to this argument, retrenchment may have positive effects by causing people to re-think, re-evaluate and search for alternative methods of cutting costs and allocating funds. The family planning program is currently undergoing this process. Methods for cutting costs and stretching dollars are being explored so that services will not be reduced.

The research reported here is a feasibility study of one method by which the Family Planning program might save dollars in order to maintain present levels of services in the face of declining budgets. This method centers on the group purchasing of contraceptives. The present chapter explores the problem of rising health care costs in our country and the need for financial retrenchment as programs are faced with decreased funds. Within their control, various options for maximizing family planning dollars in Montana will be discussed with

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[2]Robert P. Biller, "Leadership Tactics for Retrenchment," Public Administration Review (November-December 1980):605.

the remaining portion of the paper devoted to exploring the feasibility of group purchasing of contraceptives.

Purpose and Origin of the Federally Funded Family Planning Program

In order to underscore the importance of maximizing federal family planning dollars, it is first necessary to explore the purposes of the program, the services it provides, and the documented need and successes of those services. Congress enacted the Family Planning Services and Population Research Act of 1970 (Public Law 91-572) in order to enable persons who desire family planning care the access to the necessary services. This Act added Title X, "Population Research and Voluntary Family Planning Programs," to the Public Health Service Act. The mission of Title X, as outlined in the Program Guidelines, is "to provide individuals the information and means to exercise personal choice in determining the number and spacing of their children."[3] The Federal Register details further that all services must be voluntary without any coercion and must not be a prerequisite for eligibility or receipt of any other services.[4]

The Alan Guttmacher Institute, in a paper prepared for the Planned Parenthood Federation of America, sees the government's decision to fund family planning services as a result of three concerns: all persons should be able to determine the number and

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[3]U.S., Department of Health and Human Services, Program Guidelines for Project Grants for Family Planning Services (1981), p.1.

[4]U.S., Department of Health and Human Services, Federal Register, 45 (Tuesday, June 3, 1980).

spacing of their children; the health and well-being of women and children should be assured; and an effort should be made to reduce poverty and dependency.[5] Although the program's first priority is to serve low-income individuals, the basic goal of the program is to make medical family planning services available to persons from all socioeconomic groups who desire them but cannot or prefer not to obtain them from private physicians or other health providers.

The Data Analyses for 1980 Revision of DHHS Five-Year Plan for Family Planning Services identifies the major function of organized family planning services as introducing effective methods of contraception to low-income women. The program has accomplished this function, according to the study. Prior to clinic enrollment, about two-thirds of new patients in 1979 had used no method (fifty-five percent) or had used the diaphragm, spermicide or other less effective methods (ten percent). After enrolling in a family planning clinic, about an equal proportion chose the most effective methods--pills, IUD's and sterilization.[6] In 1983, nearly five million women received family planning services from organized providers in the United States, an increase of 4.1 million patients since 1968 when federally subsidized organized family planning services began with an annual caseload of 863,000.[7]

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[5]Alan Guttmacher Institute, "Major Sources of Federal Funds for Family Planning Services," New York, 1981.

[6]Alan Guttmacher Institute, Data Analyses for 1980 Revision of DHHS Five Year Plan for Family Planning Services, New York, 1981.

[7]Alan Guttmacher Institute, Organized Family Planning Services in the United States, 1981-1983, New York, December 1984, p. 1.

Benefits of Federally Funded Family Planning Programs

The benefits which can be attributed to federally funded family planning programs have been documented by various individuals. According to Kristin A. Moore and Steven B. Caldwell in their study, "The Effects of Government Policies on Out-of-Wedlock Sex and Pregnancy," the availability of subsidized family planning services does seem to lower pregnancy rates. They found that states which prohibited the provision of family planning services to teenagers had significantly higher out-of-wedlock birthrates among blacks aged 15-19. Their findings indicated, however, that even when services are available, use of contraceptives among young, unmarried people frequently is erratic and ineffective. Their recommendation, therefore, was that the provision of better family planning services and more information to those who want them should be an important policy goal in view of the effect the program has on reduced pregnancy rates.[8]

An analysis of the costs and benefits of family planning programs is provided by Mary Chamie and Stanley K. Henshaw.[9] They estimate that in 1979, federally funded family planning programs prevented about 695,000 pregnancies among low and marginal income women. These pregnancies would have resulted in 239,000 births,

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[8]Kristin A. Moore and Steven B. Caldwell, "The Effect of Government Policies on Out-of-Wedlock Sex and Pregnancy," Family Planning Perspectives (July/August 1977):164.

[9]Mary Chamie and Stanley K. Henshaw, "The Costs and Benefits of Government Expenditures for Family Planning Programs," Family Planning Perspectives (May/June 1981):117.

370,000 abortions and 86,000 miscarriages. Their study also estimated that for every dollar spent by the government on family planning services, two dollars were saved the next year in public sector expenditures for child birth, postnatal and pediatric care, abortions and welfare payments.

Another benefit of the program, lowered fertility rates, was described in a study conducted by Phillip Cutright and Frederick S. Jaffe.[10] As a result of their study, they contended that the larger the proportion of lower socioeconomic status women enrolled in organized family planning programs, the lower their fertility. They concluded that, "The U.S. family planning program has--independent of other sociodemographic factors--reduced the fertility of low-income women by helping them to prevent unwanted and mistimed births."

Family Planning in Montana

Presently, there are 15 federally funded family planning programs located in Montana providing medical, counseling, and contraceptive services to over 21,000 women annually. As Table 1 depicts, family planning dollars in Montana increased from $297,860 at the program's inception in 1972 to $834,265 at its peak in 1981. Between 1981 and 1984, however, funds were reduced by more than 16 percent to $698,637.

Although the current year, 1985, showed an unexpected increase, inflation has also increased the costs associated with the program.

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[10]Phillips Cutright and Frederick S. Jaffe, "Family Planning Program Effects on the Fertility of Low-Income U.S. Women," Family Planning Perspectives (May/June 1976):105.

TABLE 1

TITLE X FAMILY PLANNING FUNDING
MONTANA 1972 - 1985

Fiscal Year	Funding	Fiscal Year	Funding
1972	$297,860	1979	$738,631
1973	498,873	1980	742,769
1974	563,873	1981	834,265
1975	569,873	1982	833,165
1976	579,579	1983	720,540
1977	486,955	1984	698,637
1978	804,128	1985	807,514

This is particularly true in regards to rising pharmaceutical costs. Costs for the most widely used brand of birth control pills, for example, have risen from 22¢ per cycle in 1981 to $1.25 in 1984 (a 568 percent increase) and IUD's have risen from $12.00 in 1981 to $30.00 in 1984. These increases are significant in that 15 percent of some agencies' total budgets are allocated for purchasing contraceptives. It is evident from the foregoing that increased costs and reduced federal funds have created the need for family planning programs to explore alternative methods of reducing costs and providing the most services for the limited dollars available.

Financial Retrenchment

The recent family planning experience parallels that of a multitude of public agencies who are currently suffering fiscal decline and exploring ways to manage it. During the past several decades, the public sector has experienced growing resources. In recent years, however, resources have been declining, ushering in an era of retrenchment. Robert Behn describes retrenchment as turning an organization "into one that is smaller, doing less, consuming fewer resources, but still doing something and doing it well."[11] It seems, therefore, that retrenchment causes people to re-think, re-evaluate, and search for ways to continue functioning on reduced funds. With this process, the outcomes of retrenchment can be positive. The

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[11]Robert P. Behn, "Leadership for Cut-Back Management: The Use of Corporate Strategy," Public Administration Review (November/December 1980):615.

process itself, however, is usually not a pleasant one and problems will normally be encountered. Robert Biller identifies some of these problems: 1) people will resist retrenchment--their status, income, benefits and future may be in jeopardy; 2) surprise abounds--retrenchment is too complex to predict; 3) the poor are hurt--expenditures are reduced, usually to the disadvantage of the poor, who benefited from the programs; 4) flexibility is decreased--slack and excess spending is reduced, new people are let go; 5) innovation is dampened--resources are usually not available for new programs or needs, but instead are used for existing programs; and 6) costs can be increased--there are costs associated with terminating a program that are not always considered.[12]

One of the first steps in retrenchment is to convince the public that retrenchment is necessary. The public has lived with increases for so long that they will not believe cutbacks are necessary or permanent. According to Charles Levine, almost all of our current management strategies are based upon assumptions of continued growth. Budgeting is thought of as incremental additions to a secure base.[13] Robert Behn describes the political problems involved in making the public aware of declines. Anyone who attempts to explain a long-term decline will be ridiculed; elected leaders who announce that resources are declining and cutbacks must be made will be voted out of office;

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[12]Robert P. Behn, "Leadership in an Era of Retrenchment," Public Administration Review (November/December 1980):605.

[13]Charles H. Levine, "Organizational Decline and Cutback Management," Public Administration Review (July/August 1978):316.

and appointed administrators will lose support, effectiveness and confidence.[14]

In order to have insight into future funding while planning retrenchment efforts, it is necessary to analyze and recognize underlying trends, such as demographic patterns, economic behavior, social attitudes, political power, tax bases, and legislative support.[15] Although family planning is experiencing a decrease in funds, there is speculation as to whether or not the decline will be permanent. An analysis of the factors involved indicates that policies of the current administration in Washington are such that Family Planning has been an area targeted for reduced funding and more stringent administrative controls. These administrative controls consist of attempts to restrict services to teens, diverting funds from service delivery into "priority areas" such as natural family planning and family involvement, and moving the Office of Family Planning in the Department of Health and Human Services to an agency administered by a political appointee rather than a career civil servant as in the past. In addition, the controversial nature of the program makes it susceptible to current "new right" and "moral majority" policies.

While these factors are causes of the current declines, there are underlying issues which indicate that policy makers should re-evaluate their current decisions regarding the Family Planning

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[14]Robert P. Behn, "Leadership for Cut-Back Management: The Use of Corporate Strategy," Public Administration Review (November/December 1980):615.

[15]Ibid.

Program. These issues are: the continually increasing number of sexually active teenagers, the increasing number of out-of-wedlock births, and the increasing number of low-income women needing family planning services as health care costs continue to increase. Supporters of the program, therefore, are optimistic that a change in administration and/or a re-evaluation of policies will restore funding levels. This line of thinking, however, may be seen as what Charles Levine calls the "Tooth Fairy Syndrome." This refers to the fact that during initial cutbacks, people do not believe the cuts are real or permanent. Instead, they are optimistic the cuts will be restored.[16]

Regardless of whether the optimism is warranted or not, the reality of the need for some retrenchment efforts is evident and ways to deal with Family Planning funding declines in the face of increased program costs are being sought. The depth of the retrenchment efforts, however, will depend upon the perceived permanence of the funding cuts. Across-the-board cuts and cost-saving measures are being evaluated more seriously than other options, such as closing programs and laying off large numbers of employees. The latter options would be utilized if initial strategies failed to provide sufficient remedies for continually decreasing funds. The Family Planning Program, therefore, is in the first of two stages of retrenchment. Robert Behn discusses the first stage as small declines in resources and the optimism that it is not a long-term trend. This results in across-the-board cuts and deferred maintenance. The second

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[16]Charles H. Levine, "More on Cutback Management: Hard Questions for Hard Times," Public Administration Review (March/April 1979):181.

stage results when the permanence of the situation is believed and long-term solutions are sought.[17]

Rising Health Care Costs

While a decline in funds is the main cause of retrenchment efforts in the Family Planning Program, rising health care costs have also contributed to the need for retrenchment. Since Family Planning Programs provide medical and contraceptive services, increased health care costs, especially pharmaceutical costs, have had an impact on the program. Nationally, expenditures for health care have nearly doubled since 1970. National health care costs as a percentage of gross national product have risen from 4.5% in 1955 to 10% in 1983.[18] In the past year alone, health care costs rose 11.9% while the consumer price index rose only 3.9%.[19] On a local level, Montana's expenditures for health care were $906.3 million in 1983, an increase of 9.7% over 1982's figure of $825.9 million.[20] Expenditures for

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[17]Robert P. Behn, "Leadership for Cut-Back Management: The Use of Corporate Strategy," Public Administration Review (November/December 1980):615.

[18]Kristina Burkhart, J.D., and Craig G. Burkhart, J.D., "Health Care Costs and the American Lifestyle: Views of the Professional," Ohio State Medical Journal 78 (December 1983): 824.

[19]"Nation Faces Serious Problem of Rising Health Care Costs: Spending Grows Faster than Economy," Pennsylvania Nurse (February 1984):11.

[20]Montana State Department of Health and Environmental Sciences, Bureau of Health Planning, "Montana Health Care Expenditures by Type and Source of Expenditure - 1983",November, 1984.

pharmaceuticals in the United States have risen from $1.7 billion in 1950 to $19.2 billion in 1980 and are estimated to reach $44.4 billion by 1990.[21] As a result, the search for new and better policies to contain the high cost of health care is likely to grow more intense.

Walter J. McNerney, in The New England Journal of Medicine, discusses the problems underlying rising health care costs in terms of the influence of "demand pull" and "supply push." The factors contributing to demand, according to McNerney, have been increasing insurance coverage, rising personal income, and greater faith in the curative powers of medicine. On the other hand, the factors influencing supply are the increasing number of doctors and hospital beds, advances in science and technology which require more capital equipment and skilled labor, and an inability of labor-intensive personal-service institutions to achieve gains in productivity.[22]

Regardless of the causes of increased health care costs, the Family Planning Programs are spending an increasing proportion of their budgets on expenditures for health care, especially pharmaceuticals in the form of contraceptives. As previously mentioned, increases in contraceptive prices are significant in that 15 percent of some agencies' budgets are allocated for purchasing contraceptives.

It is evident from the foregoing analysis that increased costs

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[21]James Fralick, "Rx for Treatment of Hyper Health-Care Costs," Across the Board, April 1982, p. 68.

[22]Walter J. McNerney, "Control of Health Care Costs," The New England Journal of Medicine (November 1980):1089.

and reduced federal funds have created the need for Family Planning Programs to explore methods of reducing costs and to find alternative ways of providing the most services for the limited dollars available. The following chapter will discuss possible options, with the remaining portion of the paper devoted to exploring the feasibility of one option--group purchasing of contraceptives.

CHAPTER II

EXPLORING OPTIONS IN THE FACE OF RETRENCHMENT

According to Robert Biller, one of the most frequent hazards of an organization experiencing retrenchment is to develop more elaborate accounting and control systems when what is really needed is a more distanced, playful, responsive, inventive set of responses.[1] His idea, it seems, suggests more experimentation with possible options. He sees our current practices as punitive and impractical rather than rewarding and practical and feels substantial resources can be recovered if we can change our methods. Following this approach, the Family Planning Program has done some re-evaluating in order to identify possible options and to make retrenchment as "rewarding and practical" as possible. The following portion of this chapter discusses these options.

Across the Board Cuts vs. Selective Cuts

As family planning funds were reduced, decisions had to be made regarding how the cuts would be distributed. Two alternatives existed: 1) give all programs the same percentage of a cut (across-the-board cuts); or 2) distribute the cuts in a manner which would reduce the negative effects of the decreased dollars. Federal dollars for family planning services are allocated to each of the ten Federal regions in the country through use of a formula based

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[1]Robert P. Biller, "Leadership Tactics for Retrenchment," Public Administration Review (November/December 1980):608.

primarily upon the numbers of low-income women served in those regions. The Regional Offices, in turn, allocate the funds to the states primarily on the number of low-income women served in each state. Since the funds are distributed upon such a competitive basis, the issue of how to distribute the cuts becomes even more complex. If funds were reduced across the board, and all programs received an equal cut, the number of women served would decline as would the dollars received in the State next year. On the other hand, if cuts were distributed so that providers serving the most clients and thus bringing the most dollars into the State were not cut, more dollars could be expected into the State.

In addition, reducing funds to small clinics versus large clinics raises a philosophical issue. Should the Federal Title X funds be used to provide services to all women, regardless of geographical location, or should the funds be used to serve the most women possible? The first option would support funding family planning clinics in rural areas as well as more populated areas in order to give all people access to the services. The second option would support funding clinics which serve the most women and reducing or closing rural programs whose numbers of clients are low. Charles Levine refers to this decision as a tradeoff between equity and efficiency. "Equity" refers to the distribution of cuts across organizations while "efficiency" refers to allocating cuts so that long-term losses to the entire organizations are minimized.[2]

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[2]Charles H. Levine, "Organizational Decline and Cutback Management," Public Administration Review (July/August 1978):302.

Levine's writing further supports the experiences the State Family Planning administration encountered. Cuts on the basis of equity are easier--they are more socially acceptable, easier to justify and involve fewer decisions. Efficiency cuts, on the other hand, involve costly analysis in weighing the value of people and programs.[3] After lengthy discussions and analysis, across-the-board cuts were made to the Family Planning Programs in the State. Robert Biller supplies some support for across-the-board cuts as he feels this method increases the perception of fairness and legitimacy. Instead of retrenchment causing conflicts and divisions, it can become integrating and help the entire organization believe in the fairness of the cuts and become committed to the need for retrenchment.[4]

Implementing a Capitation System

Federal Title X funds in Montana are currently allocated to the 15 Family Planning Programs in the State through use of an allocation formula. The formula considers the following items: 1) number of clients served; 2) number of low-income clients served; 3) cost per client; 4) quality; and 5) programmatic value--a factor which considers financial reports, board involvement, community outreach and collections from client fees and donations. The allocation formula is based upon the principle of rewarding programs for their performance. Since there is a fixed amount of dollars available for distribution in

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[3]Ibid.

[4]Robert P. Biller, "Leadership Tactics for Retrenchment," Public Administration Review (November/December 1980):607.

the State, the 15 programs must "compete" with each other for these dollars. Programs with an increase in total clients and low-income clients, decreased costs, and improved quality will be rewarded with increased funds the following year.

A capitation system is one option which could be used to further enhance the allocation process and thus make the distribution of funds more equitable between the large and small clinics. Under this method, all clinics would be reimbursed a fixed amount for each client served, thus, all clinics would be treated equally and inefficient clinics would be forced to become more cost effective in order to survive within their budget.

The performance-based allocation formula would be used to set each program's ceiling, or maximum amount of Title X funds they could receive. Programs would then "earn" those funds by being reimbursed a fixed amount for every client seen. Inefficient programs would be forced to become more cost effective in order to achieve their ceiling. For example, a program whose cost per client is $120 may only be reimbursed $80 per client through the capitation system. That clinic would need to increase the number of clients served in order to reach its maximum allocation.

Terminating Programs

Another option for reducing costs and maximizing dollars is to consider closing small, rural family planning programs. Because of the small number of clients seen in these programs (123-222 per year) and the costs associated with serving them, they are not as cost effective as the larger programs. The statewide average cost per

client is $79, while cost per client in the smaller programs is as high as $231 per client. Again the philosophical issue surfaces of who should receive services. Should rural areas be penalized because their costs are higher than the costs in larger population centers?

At this time, no family planning programs in Montana have been closed. As across-the-board cuts have been made, all programs have been forced to re-evaluate their operation and to seek ways of increasing other sources of revenue. Since the allocation formula is performanced-based, as mentioned previously, incentive is evident for clinics to increase their clients and decrease their costs. In addition, special emphasis has been given to providing technical assistance to clinics in the areas of marketing and clinic efficiency.

During discussions regarding the possibility of closing programs, it was decided that programs would not be told they would no longer be funded. Instead, funds would be allocated through the formula based upon their performance and if a program reached a point in their funding where they felt they could no longer function, it would be the program's decision to close its doors. All programs are continuing to function and have increased their efforts to secure additional revenue from other sources, such as county funds, United Way, etc.

Statewide Contract for Pap Smears

The Family Planning Programs in Montana perform approximately 13,000 pap smears per year. The pap smears must be sent to a laboratory for analysis at a cost ranging from $2.50 to $7.00 each. Since there was such a wide range in the cost of the laboratory

services, it was determined that a statewide contract would reduce the dollars currently being spent for those services. A questionnaire was developed which incorporated quality features of the laboratory along with cost. The questionnaire with request for bids was mailed to all laboratories currently providing services to the clinics. After the questionnaires were received, an analysis was done to determine which laboratory offered the best quality for the lowest price. International Cancer Screening Laboratories, Inc., who offered tests at $2.20, was chosen. All clinics were notified of the results and were encouraged to utilize that laboratory. At this point, a statewide contract has not yet been developed.

Increased Emphasis on Patient Fees and Donations

As federal funds have declined, alternative sources of funds were sought to fill the gap. Charges for services provided in federally-funded family planning programs must be based on the client's ability to pay. Federal guidelines specifically prohibit charges being assessed to clients who are below 100% of the poverty level ($10,200 per year for a family of four).[5] Full charges must be assessed to clients above 200% of the poverty level ($20,400 per year for a family of four). Charges to all other clients must be made in accordance with a schedule of discounts where clients pay 25%, 50%, or 75% of the full charge, depending upon their income and family size. Since the Guidelines are very specific as to who must and must not be

[5]U.S., Department of Health and Human Services, Program Guidelines for Project Grants for Family Planning Services (1981), p.4.

charged for services, such things as instituting a minimum charge for services for all clients is not possible.

Other areas that have been explored in an attempt to increase client revenues include raising clinic fees to assure the fees were adequate to cover their costs, instituting accounts receivable systems to track revenue for evaluation and accountability purposes, decreasing the amount of outstanding accounts, and encouraging client donations. Clinic directors were encouraged to re-evaluate their charges in order to assure that their charges were competitive within their community yet were covering their costs. Donations were actively encouraged and have proven to be a very valuable source of additional revenue. Clients who are eligible for free or reduced services are often willing to make a donation in order to help assure continued services. One program is currently collecting an average of $1,443 per month in donations.

Group Purchasing of Contraceptives

This option remains to be explored and constitutes the next chapter in this paper. The feasibility of group purchasing will be analyzed and an estimate made of the potential cost savings from such a system. All 15 Family Planning Programs currently purchase their contraceptives individually from various companies. A guiding hypothesis of the following study is that significant savings are possible if all family planning programs purchase contraceptives collectively. According to the American Journal of Hospital Pharmacy, "Group purchasing of pharmaceuticals has been responsible for substantial cost savings in many hospitals..."[6] The logic of group

purchasing is economies of scale--competing companies will generally respond to a large volume of purchases with reduced prices. The National Chamber Foundation, in its publication, How Business Can Use Specific Techniques to Control Health Care Costs, describes volume purchasing of drugs as a means of lowering prices and thus reducing costs.[7] It is with this assumption that the feasibility study described in the following chapter was undertaken.

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[6]C. Richard Talley, "Group Purchasing of Pharmaceutical Cuts Millions from Health Care Costs," American Journal of Hospital Pharmacy (August 1979):1128.

[7]National Chamber Foundation, How Business Can Use Specific Techniques to Control Health Care Costs, (Washington, D.C., 1978), p. 22.

CHAPTER III

FEASIBILITY OF GROUP PURCHASING

Contraceptives Currently Used

The first step in assessing the feasibility of group purchasing was to determine the different types, quantities, and costs of contraceptives currently being purchased in the 15 family planning programs in Montana. This was accomplished through developing a survey which was sent to each of the Family Planning Program Directors in the State. The survey was divided into six sections, one for each of the contraceptive methods: oral contraceptives; IUD's; diaphragms; condoms; foam, jelly, cream; and the contraceptive sponge. The sections contained columns to list the following information on each contraceptive: the manufacturer's name, brand/strengths, amount projected for the next 12 months, and the current cost. Table 2 summarizes the results from the 15 programs surveyed.

Survey Results

Oral Contraceptives

A total of 17 different oral contraceptives manufactured by four different companies were currently being used by the 15 programs. The total number of cycles estimated for the next year was 139,962. Costs ranged from a low of $0.60 per cycle (a Planned Parenthood affiliate)

TABLE 2

SUMMARY OF CONTRACEPTIVES CURRENTLY USED
IN THE FIFTEEN FAMILY PLANNING PROGRAMS

Company Name	Brand/ Strength	Number Projected	Average Current Cost
Oral Contraceptives			
Ortho Pharmaceutical	Ortho Novum 10/11	3,968	$1.00-1.25*
Ortho Pharmaceutical	Ortho Novum 1/35	45,658	1.00-1.25*
Ortho Pharmaceutical	Ortho Novum 1/50	32,733	1.00-1.25*
Ortho Pharmaceutical	Ortho Novum 1/80	1,054	1.00-1.25*
Ortho Pharmaceutical	Ortho Novum 777	17,058	1.00-1.25*
Ortho Pharmaceutical	Modicon	1,538	1.00-1.25*
Wyeth Laboratories	Ovral	8,243	1.75
Wyeth Laboratories	Lo-Ovral	16,344	1.75
Wyeth Laboratories	Nordette	6,651	1.75
Wyeth Laboratories	Ovrette	73	1.75
Parke-Davis	Norlestrin 1/50	3,198	1.92
Parke-Davis	Norlestrin 2.5	600	1.92
Parke-Davis	Lo-Estrin 1/20	50	1.92
Parke-Davis	Lo-Estrin 1.5/30	870	1.92
Searle Laboratories	Demulen 1/50	1,696	2.45
Searle Laboratories	Demulen 1/35	108	2.45
Searle Laboratories	Ovulen	120	2.45
IUD			
Searle Laboratories	CU-7	561	30.00
Ortho Pharmaceutical	Lippes Loop	92	10.15
ALZA Corp.	Progestasert	59	13.80
Diaphragm			
Ortho Pharmaceutical	All flex/coil	1,824	3.60
Condoms			
Planned Parenthood	. . .	10,184	0.075
Circle Rubber Corp.	(Assorted)	17,280	0.069-0.139

*The two Planned Parenthood affiliates in the state received these contraceptives at $0.60 to $0.64/cycle. All other programs paid either $1.00/cycle or $1.25/cycle.

TABLE 2 - Continued

Company Name	Brand/ Strength	Number Projected	Average Current Cost
Condoms (continued)			
Youngs Drug Products	Trojans	2,000	0.06
Schmid Products Co.	Sheik Esq.	3,746	0.055
Ansell, Inc.	Prime	14,952	0.058
Foam/Jelly/Cream			
Ortho Pharmaceutical	Delfen Foam	712	$1.57
Ortho Pharmaceutical	Conceptrol Gel	570	2.98
Ortho Pharmaceutical	Ortho Gynol Creme	3,498	1.06
Ortho Pharmaceutical	Intercept	924	2.56
Schering Corp.	Emko Foam	1,120	1.43
Schering Corp.	Because Foam	600	1.20
Whitehall Laboratories	Semicid	60	3.25
Youngs Drug Products	Koromex Foam	219	1.55
Youngs Drug Products	Contraceptive Jelly	175	0.80
Contraceptive Sponge			
VLI Corp.	. . .	4,856	0.50

to a high of $2.45. The $0.60 per cycle was available only to the two Planned Parenthood Affiliates in the State. These two programs belong to the Planned Parenthood Federation of America (PPFA). Through their membership, they are entitled to participate in an arrangement PPFA has negotiated on a national level with a few pharmaceutical companies to obtain contraceptives at reduced prices. Only Planned Parenthood Affiliates can participate in this arrangement, and the affiliates are prohibited from selling the contraceptives obtained through this arrangement to non-Planned Parenthood affiliates.

The most widely used oral contraceptives were the Ortho Novum products, manufactured by Ortho Pharmaceuticals. Prices for these contraceptives were either $1.00 per cycle or $1.25 per cycle. Wyeth's contraceptives were being purchased for $1.75 per cycle in all programs. Parke-Davis' prices ranged from $1.00 to $3.75 per cycle. Programs who had recently purchased these products were paying $3.75 per cycle. It appears, therefore, that the average price of $1.92 per cycle includes contraceptives which were purchased under a now outdated pricing schedule. Searle Laboratories contraceptives were all $2.45 per cycle.

IUD's

The survey indicated that three different IUD's manufactured by three companies were being used. One IUD, the CU-7, was significantly more expensive than the other IUD's. The average cost for the CU-7 was $30.00. The programs estimated purchasing 712 IUD's within the next year, including 561 CU-7's.

Diaphragms

All diaphragms used in the 15 programs were manufactured by Ortho Pharmaceutical Corporation. The price in all programs was $3.60. A total of 1,824 diaphragms were estimated for the next year.

Condoms

Five different condoms manufactured by five companies were listed on the surveys. Costs ranged from $0.055 to $0.139 with an estimated 48,162 to be purchased.

Foam, Jelly, Cream

The survey listed nine different foam, jelly or cream products manufactured by four companies. A total of 7,878 foam, jelly or cream products were estimated to be needed.Foam products ranged from $1.20 to $1.57, while jelly and cream products ranged from $0.80 to $2.98. The suppositories, Semicid and Intercept, ranged from $2.56 to $3.25.

Contraceptive Sponge

The contraceptive sponge is manufactured by only one company, VLI Corporation. All programs were paying $0.50 each. It was estimated that 4,856 would be needed.

Determining Prices Available Through Group Purchasing

After the information received from the family planning programs was compiled, a form was developed to be sent to manufacturers supplying contraceptives to the family planning programs. A cover letter explaining the feasibility study and the number of contraceptives currently being used was developed along with an individualized form for each manufacturer which listed the products the family planning programs in the State were currently purchasing.

Each manufacturer was asked to complete and return the form if they were interested in providing their products to the 15 federally funded Family Planning Programs in the State at competitive prices. The following information was requested: price for each product, minimum volume necessary, method of shipment, if prices included freight, how long the prices would be in effect, and a contact person.

Letters were sent to 13 contraceptive manufacturers throughout the United States. Responses were received from seven. Since six manufacturers did not respond, it was assumed that they were not interested in offering a competitive price based upon a volume purchase. For purposes of analysis in this paper, therefore, it was assumed that the price currently being offered to the family planning programs in the State was the lowest price available from those six manufacturers. Table 3 summarizes the information received.

Analysis

Table 4 shows a comparison of the prices the 15 family planning programs are currently paying and the price which would be available through a group purchase arrangement. The fact that only one oral contraceptive manufacturer responded had a significant impact on the results of the feasibility study. Since oral contraceptives represent the majority of contraceptives purchased, substantial savings could not be realized if reduced oral contraceptive prices were not available.

Of the seven manufacturers which did respond, it appears that the family planning programs are already obtaining the lowest price available with one exception. ALZA Corporation offered the

TABLE 3

SUMMARY OF RESPONSES RECEIVED
FROM MANUFACTURERS

Manufacturer/ Product	Price	Minimum Volume	Drop Shipment	Do Prices Include Postage	Length of Time Prices Effective
Oral Contraceptives					
Wyeth Laboratories					
All brands . . .	$1.75	6 cycles	yes	yes	7 months
IUD					
ALZA Corp.					
Progestasert . .	9.25	6	yes	yes	6 months
Condoms					
Circle Rubber Corp.	0.069-0.139	$50.00	yes	no	12 months
Youngs Drug Products -					
Trojans	0.06	$50.00	yes	no	. . .
Schmid Products					
Sheik Esq. . . .	0.05	$125.00	yes	yes	60 days
Ansell Inc.					
Prime	0.076	$50.00	yes	yes	16 months
Foam/Jelly/Cream					
Schering Corp.					
Emko Foam . . .	1.43	$50.00	yes	no	12 months
Because	1.20	$50.00	yes	no	12 months
Youngs Drug Products -					
Koromex Foam . .	1.66	$50.00	yes	no	. . .
Contraceptive Jelly	0.80	$50.00	yes	no	. . .

TABLE 4

COMPARISON OF CURRENT PRICES AND THOSE AVAILABLE THROUGH A GROUP PURCHASE ARRANGEMENT

Manufacturer	Product	Current Price	Group Purchase Price
Oral Contraceptives			
Ortho Pharmaceutical	Ortho Novum 10/11	$1.00-1.25	No response
Ortho Pharmaceutical	Ortho Novum 1/35	1.00-1.25	No response
Ortho Pharmaceutical	Ortho Novum 1/50	1.00-1.25	No response
Ortho Pharmaceutical	Ortho Novum 1/80	1.00-1.25	No response
Ortho Pharmaceutical	Ortho Novum 777	1.00-1.25	No response
Ortho Pharmaceutical	Modicon	1.00-1.25	No response
Wyeth Laboratories	Ovral	1.75	$1.75
Wyeth Laboratories	Lo-Ovral	1.75	1.75
Wyeth Laboratories	Nordette	1.75	1.75
Wyeth Laboratories	Ovrette	1.75	1.75
Parke-Davis	Norlestrin 1/50	1.92	No response
Parke-Davis	Norlestrin 2.5	1.92	No response
Parke-Davis	Lo-Estrin 1/20	1.92	No response
Parke-Davis	Lo-Estrin 1.5/30	1.92	No response
Searle Laboratories	Demulen 1/50	2.45	No response
Searle Laboratories	Demulen 1/35	2.45	No response
Searle Laboratories	Ovulen	2.45	No response
IUD			
Searle Laboratories	CU-7	30.00	No response
Ortho Pharmaceutical	Lippes Loop	10.15	No response
ALZA Corp.	Progestasert	13.80	9.25
Diaphragm			
Ortho Pharmaceutical	All flex/coil	3.60	No response
Condoms			
Planned Parenthood	. . .	0.075	Not available
Circle Rubber Corp.	(Assorted)	0.069-0.139	0.069-0.139
Youngs Drug Products	Trojans	0.06	0.06
Schmid Products Co.	Sheik Esq.	0.055	0.05
Ansell, Inc.	Prime	0.058	0.076

TABLE 4 - Continued

Manufacturer	Product	Current Price	Group Purchase Price
Foam/Jelly/Cream			
Ortho Pharmaceutical	Delfen Foam	$1.57	No response
Ortho Pharmaceutical	Conceptrol Gel	2.98	No response
Ortho Pharmaceutical	Ortho Gynol Creme	1.06	No response
Ortho Pharmaceutical	Intercept	2.56	No response
Schering Corp.	Emko Foam	1.43	$1.43
Schering Corp.	Because Foam	1.20	1.20
Whitehall Laboratories	Semicid	3.25	No response
Youngs Drug Products	Koromex Foam	1.55	1.66
Youngs Drug Products	Contraceptive Jelly	0.80	0.80
Contraceptive Sponge			
VLI Corp.	. . .	0.50	No response

Progestasert IUD at $9.25 compared to an average of $13.80 currently being paid in the 15 programs. The $9.25 price for the Progestasert IUD would represent a savings of $4.55 per IUD for a total of $268 (it was estimated that 59 would be purchased). The responses from the seven manufacturers indicate, therefore, that group purchasing would not result in significant contraceptive cost reductions.

CHAPTER IV

RECOMMENDATIONS

Summary

The guiding hypothesis of this paper was that significant savings would be possible if all family planning programs in the State purchased contraceptives collectively. The analysis conducted in the previous chapter indicates that this is not the case. The results show that except in one instance, the family planning programs are currently obtaining the lowest prices available and group purchasing would not further reduce the prices.

It was assumed that manufacturers would respond to a request for competitive bids in order to assure their share of the market. As this was not the case, some speculation was indicated on possible reasons for both the lack of response and/or the manufacturers' unwillingness to further reduce their prices.

The responses received from Youngs Drug Products, Schering Corporation, and Circle Rubber Corporation indicated that their prices were "family planning clinic" prices. A telephone conversation with the Sales Manager from Youngs Drug Products confirmed the fact that his company had two price lists, one for federally funded family planning clinics and one for other retailers (pharmacies, drug stores, etc.). Since family planning clinics were already receiving

substantial discounts, further price reductions were not possible.

Another possible reason for the lack of response could be that Montana's volume is not significant enough to warrant competitive bids from manufacturers. Planned Parenthood Federation of America has been successful in negotiating contracts with a small number of manufacturers for reduced prices. Since the negotiating was done on a national level for the approximately 698 Planned Parenthood clinics in the United States, their volume would represent a very significant number of contraceptives. Montana's volume, of course, could not begin to compare with that of a national organization.

Another organization, the National Family Planning and Reproductive Health Association (NFPRHA), attempted within the last few months to negotiate a contract with Syntex, an oral contraceptive manufacturer. NFPRHA is a national organization devoted to the expansion and improvement of the delivery of family planning and reproductive health care. The organization was not successful in their attempts to negotiate a contract with Syntex as a commitment of six million cycles over the next year was needed in order for Syntex to reduce their prices. A commitment for that amount could not be obtained.

Given the foregoing information, it is understandable why Montana's request for competitive bids was not successful. Research conducted prior to the study, as discussed on page 21, indicated that group purchasing of pharmaceuticals could result in substantial cost savings. It was with this in mind that the study was undertaken. The examples cited in the research, however, differ in that family

planning programs already appear to be obtaining reduced prices by nature of their organization. Further research could be undertaken to determine if any of the manufacturers would respond to a much larger volume purchase, such as a regional group purchase arrangement involving several states.

Since cost savings were not possible through group purchasing, the question arose whether there were other benefits which could be identified to support such an arrangement. It was learned that two of the 15 Family Planning Programs in the State currently purchase their contraceptives through another family planning program, rather than directly through the manufacturer. These two programs are the smallest in the State and so have difficulty meeting some of the manufacturers' minimum shipment orders. When these programs purchase the volume required by the manufacturers, items often become out-dated before they are used. With a statewide group purchasing arrangement, however, this would not be a problem.

Eliminating the minimum order requirement was the only advantage of statewide group purchasing which could be identified. As the two programs affected already have a satisfactory arrangement to compensate for this, statewide group purchasing did not seem to be warranted.

Conclusions and Recommendations

The preceding analysis and summary has shown that group purchasing of contraceptives in Montana will not result in reduced contraceptive prices. In addition, further benefits to group purchasing could not be identified which would warrant re-structuring

the current system and establishing a central warehouse with administrative staff to conduct the group purchasing.

The recommendation of this paper, therefore, is that the present system of purchasing contraceptives should be continued.

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